STATE PLAN DEFINITION OF HMO

An organization whose primary purpose is the provision of health care services and is licensed by the New Mexico Department of Insurance to manage, coordinate and assume financial risk on a capitated basis for the delivery of a specified set of services to enrolled members in a given geographic area. The HMO must establish and maintain a comprehensive provider network to ensure sufficient provision of an enhanced array of covered medically necessary services. It must make the services it provides to its Medicaid enrollees as accessible to them (in terms of timeliness, amount, duration, and scope) as those services are to nonenrolled Medicaid recipients within the area served by the HMO. It must meet all applicable State and Federal laws and regulations regarding solvency and risk, comply with networth requirements and maintain a fidelity bond which meets the maximum amount specified under the New Mexico Insurance Code. The HMO must deposit and maintain a cash reserve with an independent trustee during the duration of the contract plus ninety (90) days and assure that Medicaid enrollees will not be held liable for any of its debts if it becomes insolvent